

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-047081

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

1510

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 5117

2 5117

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12 370

13 70

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF
J. L. Maginn, M.D.
MEDICAL CERTIFICATION

USE BLACK INK
OR
TYPEWRITER RIBBON

FILED JAN 8 1964

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph,		c. CITY OR TOWN St. Joseph,	
Length of stay in 1b 5 months		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph, Hospital		d. STREET ADDRESS 2131 So 6th	
3. NAME OF DECEASED (Type or print) First Kathleen Middle Joyce Last Guardado		4. DATE OF DEATH Month Dec Day 31 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1963
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY no	11. BIRTHPLACE (City and state or country) St. Joseph, MO
13a. FATHER'S NAME Pedro Guardado		13b. MOTHER'S MAIDEN NAME Josephine Lopez	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Pedro Guardado, St. Joseph, Mo		14. NAME OF HUSBAND OR WIFE none	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) vascular collapse central nervous system stimulation Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) toxemia DUE TO (c) bronchitis, viral			INTERVAL BETWEEN ONSET AND DEATH 12 hrs 12 hrs 26 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from 12-30-63 to 12/31/63 and last saw her alive on 12-31-63 Death occurred at 5 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED 1-3-64	
22a. SIGNATURE R. Maginn (Degree or title) MD		22b. ADDRESS 702 Julia, St. Joseph, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/3/64	23c. NAME OF CEMETERY OR CREMATORY Mt Olivet cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo
24. FUNERAL DIRECTOR John S. Esch ADDRESS St. Joseph, Mo		25. DATE RECD. BY LOCAL REG. Jan. 6, 1964	
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell			

1-2-64

Permit issued 1-2-64

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

John E. Rupp

Licensed Embalmer No. *3986*

P. O. Address *St. Joseph Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.